First Regular Session 111th General Assembly (1999)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 1998 General Assembly.

HOUSE ENROLLED ACT No. 1396

AN ACT to amend the Indiana Code concerning human services.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 27-1-25-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 1. As used in this chapter:

(a) "Administrator", **except as provided in section 7.5 of this chapter,** means a person who collects charges or premiums from, or who adjusts or settles claims on, residents of Indiana in connection with life or health coverage or annuities, whether provided for by an insurer or a self-funded plan. The term "administrator" does not include the following persons:

(1) An employer for its employees or for the employees of a subsidiary or affiliated corporation of the employer.

(2) A union for its members.

(3) An insurer, including:

(A) an insurer operating a health maintenance organization or a limited service health maintenance organization; and

(B) the sales representative of an insurer operating a health maintenance organization or a limited service health maintenance organization when that sales representative is licensed in Indiana and when it is engaged in the performance

of its duties as the sales representative.

(4) A life or health insurance agent licensed under IC 27-1-15.5 whose activities are limited exclusively to the sale of insurance.

(5) A creditor for its debtors regarding insurance covering a debt between them.

(6) A trust established under 29 U.S.C. 186 and the trustees, agents, and employees acting pursuant to that trust.

(7) A trust that is exempt from taxation under Section 501(a) of the Internal Revenue Code and:

(A) the trustees and employees acting pursuant to that trust; or

(B) a custodian and the agents and employees of the custodian acting pursuant to a custodian account that meets the requirements of Section 401(f) of the Internal Revenue Code.

(8) A financial institution that is subject to supervision or examination by federal or state banking authorities.

(9) A credit card issuing company that advances for and collects premiums or charges from its credit cardholders as long as that company does not adjust or settle claims.

(10) An individual who adjusts or settles claims in the normal course of his practice or employment as an attorney at law, and who does not collect charges or premiums in connection with life or health insurance coverage or annuities.

(11) A health maintenance organization that has a certificate of authority issued under IC 27-13.

(12) A limited service health maintenance organization that has a certificate of authority issued under IC 27-13.

(b) "Certificate of registration" refers to the certificate required by section 11 of this chapter.

(c) "Commissioner" refers to the commissioner of insurance.

(d) "Financial institution" means a bank, savings association, credit union, or any other institution regulated under IC 28 or federal law.

(e) "Insurer" means a person who obtains a certificate of authority under IC 27-1-3-20.

(f) "Person" means an individual, a corporation, a partnership, a limited liability company, or an unincorporated association.

(g) "Self-funded plan" means a plan for providing benefits for life, health, or annuity coverage by a person who is not an insurer.

SECTION 2. IC 27-1-25-7.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: **Sec. 7.5. (a) As used in this section, "administrator" means a person that administers claims for health care services under an insurance policy.**

(b) As used in this section, "health care services" has the meaning set forth in IC 27-8-11-1.

(c) As used in this section, "insurance policy" means a policy that provides the kind or kinds of insurance described in Class 1(b) or Class 2(a) of IC 27-1-5-1 on an individual, group, franchise, or blanket basis or through a preferred provider plan (as defined in IC 27-8-11-1).

(d) As used in this section, "insured" means an individual entitled to coverage under an insurance policy.

(e) As used in this section, "recode" means to change a code used by a provider of health care services on a claim for covered services provided to an insured to a different classification code using the most current edition of either of the following:

(1) International Classification of Diseases.

(2) Current Procedural Terminology.

(f) An administrator may not recode a claim unless the administrator provides written notice to the insured and the provider that the administrator has recoded the claim together with:

(1) the insurer's explanation of benefits to the insured; and

(2) an explanation of remittance to the provider of the health care services.

(g) The notification required under subsection (f) must include at least the following:

(1) An appropriate ANSI code or other reason code, or both, along with a specific description of the reasons for recoding the claim.

(2) A toll free number that the provider or the insured may use to contact the administrator to obtain additional information.

(3) The procedure that a provider may use to submit a request for a review of the initial decision to recode a claim.

(4) A list of additional information that the provider must submit in a request for a review of the initial decision to recode a claim.

SECTION 3. IC 27-8-5-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 2. (a) No individual policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless **it complies with each of the following:**

(1) The entire money and other considerations ~~therefor~~ **for the policy** are expressed ~~therein;~~ **in the policy.**

(2) The time at which the insurance takes effect and terminates is expressed ~~therein;~~ **in the policy.**

(3) ~~it~~ **The policy** purports to insure only one (1) person, except that a policy may insure, originally or by subsequent amendment, upon the application of any member of a family who shall be deemed the policyholder and who is at least eighteen (18) years of age, any two (2) or more eligible members of that family, including husband, wife, dependent children or any children under a specified age, which shall not exceed nineteen (19) years, and any other person dependent upon the policyholder.

(4) The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any ~~indorsements~~ **endorsements** or attached papers is plainly printed in ~~light-faced~~ **lightface** type of a style in general use, the size of which shall be uniform and not less than ten point with a lower-case unspaced alphabet length not less than one hundred and twenty point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and captions and subcaptions).

(5) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in section 3 of this chapter, are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "EXCEPTIONS", or "EXCEPTIONS AND REDUCTIONS", provided that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies.

(6) Each such form **of the policy,** including riders and ~~indorsements,~~ **endorsements,** shall be identified by a form number in the lower left-hand corner of the first page ~~thereof;~~ **of the policy.**

(7) ~~it~~ **The policy** contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of or reference to a statement of rates or classification of risks, or short-rate table filed with the commissioner. ~~and~~

(8) If an individual accident and sickness insurance policy or hospital service plan contract or medical service plan contract provides that hospital or medical expense coverage of a

dependent child terminates upon attainment of the limiting age for dependent children specified in such policy or contract, the policy or contract must also provide that attainment of such limiting age does not operate to terminate the hospital and medical coverage of such child while the child is and continues to be both:

~~(a)~~ **(A)** incapable of self-sustaining employment by reason of mental retardation **or mental** or physical disability; and

~~(b)~~ **(B)** chiefly dependent upon the policyholder for support and maintenance.

Proof of such incapacity and dependency must be furnished to the insurer by the policyholder within thirty-one (31) days of the child's attainment of the limiting age. The insurer may require at reasonable intervals during the two (2) years following the child's attainment of the limiting age subsequent proof of the child's disability and dependency. After such two (2) year period, the insurer may require subsequent proof not more than once each year. The foregoing provision shall not require an insurer to insure a dependent who is a mentally retarded **or mentally** or physically disabled child where such dependent does not satisfy the conditions of the policy provisions as may be stated in the policy or contract required for coverage thereunder to take effect. In any such case the terms of the policy or contract shall apply with regard to the coverage or exclusion from coverage of such dependent.

This subsection applies only to policies or contracts delivered or issued for delivery in this state more than one hundred twenty (120) days after August 18, 1969.

(b) If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state shall have advised the commissioner that any such policy is not subject to approval or disapproval by such official, the commissioner may by ruling require that such policy meet the standards set forth in subsection (a) ~~of this section~~ and in section 3 of this chapter.

SECTION 4. IC 27-8-5-19 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 19. (a) As used in this chapter, "late enrollee" has the meaning set forth in 26 U.S.C. 9801(b)(3).

(b) A policy of group accident and sickness insurance may not be issued to a group that has a legal situs in Indiana unless it contains in substance:

(1) the provisions described in subsection (c); or

(2) provisions that, in the opinion of the commissioner, are:

(A) more favorable to the persons insured; or

(B) at least as favorable to the persons insured and more favorable to the policyholder;

than the provisions set forth in subsection (c).

(c) The provisions referred to in subsection (b)(1) are as follows:

(1) A provision that the policyholder is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first, during which grace period the policy will continue in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder is liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period. A provision under this subdivision may provide that the insurer is not obligated to pay claims incurred during the grace period until the premium due is received.

(2) A provision that the validity of the policy may not be contested, except for nonpayment of premiums, after the policy has been in force for two (2) years after its date of issue, and that no statement made by a person covered under the policy relating to the person's insurability may be used in contesting the validity of the insurance with respect to which the statement was made, unless:

(A) the insurance has not been in force for a period of two (2) years or longer during the person's lifetime; or

(B) the statement is contained in a written instrument signed by the insured person.

However, a provision under this subdivision may not preclude the assertion at any time of defenses based upon a person's ineligibility for coverage under the policy or based upon other provisions in the policy.

(3) A provision that a copy of the application, if there is one, of the policyholder must be attached to the policy when issued, that all statements made by the policyholder or by the persons insured are to be deemed representations and not warranties, and that no statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the insured person or, in the event of death or incapacity of the insured person, to the insured person's beneficiary or personal representative.

(4) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for

insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the person's coverage.

(5) A provision specifying any additional exclusions or limitations applicable under the policy with respect to a disease or physical condition of a person that existed before the effective date of the person's coverage under the policy and that is not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss. An exclusion or limitation that must be specified in a provision under this subdivision:

(A) may apply only to a disease or physical condition for which medical advice, diagnosis, care, or treatment was received by the person, or recommended to the person, during the six (6) months before the enrollment date of the person's coverage; and

(B) may not apply to a loss incurred or disability beginning after the earlier of:

(i) the end of a continuous period of twelve (12) months beginning on or after the enrollment date of the person's coverage; or

(ii) the end of a continuous period of eighteen (18) months beginning on the enrollment date of the person's coverage if the person is a late enrollee.

(6) If premiums or benefits under the policy vary according to a person's age, a provision specifying an equitable adjustment of:

(A) premiums;

(B) benefits; or

(C) both premiums and benefits;

to be made if the age of a covered person has been misstated. A provision under this subdivision must contain a clear statement of the method of adjustment to be used.

(7) A provision that the insurer will issue to the policyholder, for delivery to each person insured, a certificate setting forth a statement that:

(A) explains the insurance protection to which the person insured is entitled;

(B) indicates to whom the insurance benefits are payable; and

(C) explains any family member's or dependent's coverage under the policy.

(8) A provision stating that written notice of a claim must be given to the insurer within twenty (20) days after the occurrence

or commencement of any loss covered by the policy, but that a failure to give notice within the twenty (20) day period does not invalidate or reduce any claim if it can be shown that it was not reasonably possible to give notice within that period and that notice was given as soon as was reasonably possible.

(9) A provision stating that:

(A) the insurer will furnish to the person making a claim, or to the policyholder for delivery to the person making a claim, forms usually furnished by the insurer for filing proof of loss; and

(B) if the forms are not furnished within fifteen (15) days after the insurer received notice of a claim, the person making the claim will be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which the claim is made.

(10) A provision stating that:

(A) in the case of a claim for loss of time for disability, written proof of the loss must be furnished to the insurer within ninety (90) days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of the disability must be furnished to the insurer at reasonable intervals as may be required by the insurer;

(B) in the case of a claim for any other loss, written proof of the loss must be furnished to the insurer within ninety (90) days after the date of the loss; and

(C) the failure to furnish proof within the time required under clause (A) or (B) does not invalidate or reduce any claim if it was not reasonably possible to furnish proof within that time, and if proof is furnished as soon as reasonably possible but (except in case of the absence of legal capacity of the claimant) no later than one (1) year from the time proof is otherwise required under the policy.

(11) A provision that:

(A) all benefits payable under the policy (other than benefits for loss of time) will be paid within forty-five (45) days after the insurer receives all information required to determine liability under the terms of the policy; and

(B) subject to due proof of loss, all accrued benefits under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the

insurer is liable, and any balance remaining unpaid at the termination of the period for which the insurer is liable will be paid as soon as possible after receipt of the proof of loss.

(12) A provision that benefits for loss of life of the person insured are payable to the beneficiary designated by the person insured. However, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of benefits for loss of life is subject to the provisions of the policy if no designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy are payable to the person insured. The policy may also provide that if any benefit is payable to the estate of a person, or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay the benefit, up to an amount of five thousand dollars ($5,000), to any relative by blood or connection by marriage of the person who is deemed by the insurer to be equitably entitled to the benefit.

(13) A provision that the insurer has the right and must be allowed the opportunity to:

(A) examine the person of the individual for whom a claim is made under the policy when and as often as the insurer reasonably requires during the pendency of the claim; and

(B) conduct an autopsy in case of death if it is not prohibited by law.

(14) A provision that no action at law or in equity may be brought to recover on the policy less than sixty (60) days after proof of loss is filed in accordance with the requirements of the policy, and that no action may be brought at all more than three (3) years after the expiration of the time within which proof of loss is required by the policy.

(15) In the case of a policy insuring debtors, a provision that the insurer will furnish to the policyholder, for delivery to each debtor insured under the policy, a certificate of insurance describing the coverage and specifying that the benefits payable will first be applied to reduce or extinguish the indebtedness.

(16) If the policy provides that hospital or medical expense coverage of a dependent child of a group member terminates upon the child's attainment of the limiting age for dependent children set forth in the policy, a provision that the child's attainment of the limiting age does not terminate the hospital and medical coverage of the child while the child is:

(A) incapable of self-sustaining employment because of

mental retardation **or mental** or ~~a~~ physical disability; and

(B) chiefly dependent upon the group member for support and maintenance.

A provision under this subdivision may require that proof of the child's incapacity and dependency be furnished to the insurer by the group member within one hundred twenty (120) days of the child's attainment of the limiting age and, subsequently, at reasonable intervals during the two (2) years following the child's attainment of the limiting age. The policy may not require proof more than once per year in the time more than two (2) years after the child's attainment of the limiting age. This subdivision does not require an insurer to provide coverage to a mentally retarded **or mentally** or physically disabled child who does not satisfy the requirements of the group policy as to evidence of insurability or other requirements for coverage under the policy to take effect. In any case, the terms of the policy apply with regard to the coverage or exclusion from coverage of the child.

(17) A provision that complies with the group portability and guaranteed renewability provisions of the federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191).

(d) Subsection (c)(5), (c)(7), and (c)(12) do not apply to policies insuring the lives of debtors. The standard provisions required under section 3(a) of this chapter for individual accident and sickness insurance policies do not apply to group accident and sickness insurance policies.

(e) If any policy provision required under subsection (c) is in whole or in part inapplicable to or inconsistent with the coverage provided by an insurer under a particular form of policy, the insurer, with the approval of the commissioner, shall delete the provision from the policy or modify the provision in such a manner as to make it consistent with the coverage provided by the policy.

SECTION 5. IC 27-8-10-5.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 5.1. (a) Except as provided in subsections (b) and (c), a person is not eligible for an association policy if, at the effective date of coverage, the person has or is eligible for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana as set forth in IC 27. Coverage under any association policy is in excess of, and may not duplicate, coverage under any other form of health insurance.

(b) Except as provided in IC 27-13-16-4, a person is eligible for an

association policy upon a showing that:

(1) the person has been rejected by one (1) carrier for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana, as set forth in IC 27, without material underwriting restrictions;

(2) an insurer has refused to issue insurance except at a rate exceeding the association plan rate; or

(3) the person is a federally eligible individual.

For the purposes of this subsection, eligibility for Medicare coverage does not disqualify a person who is less than sixty-five (65) years of age from eligibility for an association policy.

(c) The board of directors may establish procedures that would permit:

(1) an association policy to be issued to persons who are covered by a group insurance arrangement when that person or a dependent's health condition is such that the group's coverage is in jeopardy of termination or material rate increases because of that person's or dependent's medical claims experience; and

(2) an association policy to be issued without any limitation on preexisting conditions to a person who is covered by a health insurance arrangement when that person's coverage is scheduled to terminate for any reason beyond the person's control.

(d) An association policy must provide that coverage of a dependent unmarried child terminates when the child becomes nineteen (19) years of age (or twenty-five (25) years of age if the child is enrolled full-time in an accredited educational institution). The policy must also provide in substance that attainment of the limiting age does not operate to terminate a dependent unmarried child's coverage while the dependent is and continues to be both:

(1) incapable of self-sustaining employment by reason of mental retardation **or mental** or physical disability; and

(2) chiefly dependent upon the person in whose name the contract is issued for support and maintenance.

However, proof of such incapacity and dependency must be furnished to the carrier within one hundred twenty (120) days of the child's attainment of the limiting age, and subsequently as may be required by the carrier, but not more frequently than annually after the two (2) year period following the child's attainment of the limiting age.

(e) An association policy that provides coverage for a family member of the person in whose name the contract is issued must, as to the family member's coverage, also provide that the health insurance

benefits applicable for children are payable with respect to a newly born child of the person in whose name the contract is issued from the moment of birth. The coverage for newly born children must consist of coverage of injury or illness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for the child, the contract may require that notification of the birth of a child and payment of the required premium must be furnished to the carrier within thirty-one (31) days after the date of birth in order to have the coverage continued beyond the thirty-one (31) day period.

(f) Except as provided in subsection (g), an association policy may contain provisions under which coverage is excluded during a period of three (3) months following the effective date of coverage as to a given covered individual for preexisting conditions, as long as medical advice or treatment was recommended or received within a period of three (3) months before the effective date of coverage.

This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(g) If a person applies for an association policy within six (6) months after termination of the person's coverage under a health insurance arrangement and the person meets the eligibility requirements of subsection (b), then an association policy may not contain provisions under which:

(1) coverage as to a given individual is delayed to a date after the effective date or excluded from the policy; or

(2) coverage as to a given condition is denied;

on the basis of a preexisting health condition. This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(h) For purposes of this section, coverage under a health insurance arrangement includes, but is not limited to, coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985.

SECTION 6. P.L.147-1997, SECTION 79, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: (a) The definitions under IC 25-23.6, as amended by this act, apply throughout this SECTION.

(b) The board shall exempt an individual from the requirement under IC 25-23.6, as amended by this act, and grant the individual a mental health counselor license if the individual meets the following requirements:

(1) Submits an application to the board before ~~July~~ **August** 1, 1999.

(2) Has:

(A) at least twenty (20) years of mental health counseling experience in a joint commission accredited agency and has a bachelor's degree; or

(B) a master's or doctor's degree from an institution of higher learning in at least one (1) of the following areas:

~~(A)~~ **(i)** Counseling.

~~(B)~~ **(ii)** Clinical or counseling psychology.

~~(C)~~ **(iii)** Mental health.

~~(D)~~ **(iv)** Applied human development.

(v) Psychology.

(3) Presents evidence that the applicant is credentialed by a national organization that provides private credentialing in mental health counseling.

(4) Presents evidence from employers or professional colleagues that the applicant has at least five (5) years of mental health counseling practice within the ten (10) years preceding the date of application.

(5) Pays the fee required by the board.

(6) Has not had a license, certificate, or registration in mental health counseling or a related profession suspended or revoked in any jurisdiction.

(7) Has not been convicted of a crime that has a direct bearing on the individual's ability to practice competently.

(8) Presents evidence that the applicant has completed at least two thousand (2,000) hours of supervised client counseling before the date of application.

(c) The board shall exempt an individual from the requirement under IC 25-23.6, as amended by this act, and grant the individual a marriage and family therapist license if the individual has a current certificate as a marriage and family therapist under IC 25-23.6 or obtains this certificate no later than June 30, 1999.

(d) The board shall exempt an individual from the requirement under IC 25-23.6, as amended by this act, and grant the individual a social worker license if the individual has a current certificate as a social worker under IC 25-23.6-5 or obtains this certificate no later than June 30, 1999.

(e) The board shall exempt an individual from the requirement under IC 25-23.6, as amended by this act, and grant the individual a clinical social worker license if the individual has a current certificate as a clinical social worker issued under IC 25-23.6 or obtains this certificate no later than June 30, 1999.

(f) Notwithstanding subsections (c), (d), and (e), if the board has:

(1) taken a disciplinary action against the certificate of a:

(A) certified marriage and family therapist;

(B) certified social worker; or

(C) certified clinical social worker;

before July 1, 1997; and

(2) imposed sanctions against an individual under subdivision (1);

and the sanctions imposed under subdivision (2) remain in place, the board shall review the file of each individual described in this subsection to determine whether to grant a license to the individual as provided in this act. The board may grant a license with any restrictions the board believes are appropriate to protect the public health.

(g) This SECTION expires ~~July~~ **December** 1, 1999.

SECTION 7. [EFFECTIVE UPON PASSAGE] **(a) Before January 1, 2000, the office of the secretary of family and social services shall amend 405 IAC 2-20 and 405 IAC 5-21 to include:**

(1) school psychologists who have an endorsement as an independent practice school psychologist under IC 20-1-1.9; and

(2) advanced practice nurses under IC 25-23-1-1(b)(3) who are credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center;

as providers of Medicaid reimbursable physician or health service provider in psychology (licensed under IC 25-33-1-5.1) directed outpatient mental health services for group, family, and individual outpatient mental health services, subject to rules governing prior authorization and supervision.

(b) This SECTION expires January 1, 2000.

SECTION 8. **An emergency is declared for this act.**